

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-03-2915.M2

March 24, 2003

MDR Tracking #: M2 03 0658 01

IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient was injured on his job while installing a microwave oven when the appliance fell and hit his head and neck. As might be expected, he was suffering from a great deal of pain immediately. He sought treatment from ___, DC in ___. Treatment as conservative in nature, but of limited success. He was referred to ___, MD and a MRI was ordered, which was demonstrative of a disc bulge at C6/7. EMG indicated a possible radiculopathy at both C6 and C7, but SSEP indicated there was a radiculopathy at C8 instead. A series of epidural steroid injections was rendered to the patient with some success. The documentation indicates that he was returned to light duty initially and shortly afterward he seems to have resumed his full duty. MMI was rendered with 15% impairment as of October 3, 2002 by the treating doctor. There is no indication in the file of whether there was a designated doctor review on this case and no report is presented.

REQUESTED SERVICE

The carrier has denied the medical necessity of a neuromuscular stimulator.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

While certainly pain is difficult to control in any patient who has a radiculopathy, and sympathy should be extended to a person who has had such an unfortunate injury, there is no indication of any kind that this requested treatment would be helpful to this patient.

In fact, there may actually be a tendency for a patient to become dependent on muscle stimulators over a period of time. While the treating doctor handled this case has conservatively as possible, the requested service would not reasonably be expected to give relief from the diagnosed condition. Passive treatment at this stage is inappropriate for a patient with this diagnosis and the only treatment that this patient could expect to benefit from would be an active program of some form of exercise. As a result, I would believe that the requested service is neither reasonable nor necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 24th day of March 2002.